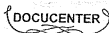


STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

W-982

(Rev. 10/06) 

DSS USE ONLY

Date Received: _____

Number Assigned: _____

PERSONAL CARE ASSISTANCE (PCA) WAIVER REQUEST

1. Personal Data

Name _____

Contact person if other than yourself:

Address _____

Name _____

Relationship _____

Telephone _____

Telephone _____

Date of Birth _____ / _____ / _____
(month) (day) (year)

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Social Security Number _____

What is your
Disability _____

I live ☐ Alone ☐ With Others

Conservator, if applicable _____

☐ In An Institution

Telephone _____

If you live with others, please identify:

Name	Relationship

2. Medicaid/Medicare Information

I am currently: ☐ On Medicaid ☐ On Spenddown
☐ Pending For Medicaid ☐ Not On Medicaid

Medicaid Number _____

I am currently on Medicare ☐ Yes ☐ No

Medicare Number _____

3. Complete This Section If You Currently Receive Any of These Services

I receive: **Home Health Aide Services** ☐ Yes ☐ No Hours Per Week _____

Agency _____

Nursing Services ☐ Yes ☐ No Hours Per Week _____

Agency _____

Physical Therapy ☐ Yes ☐ No Hours Per Week _____

Agency _____

Occupational Therapy ☐ Yes ☐ No Hours Per Week _____

Agency _____

Speech Therapy ☐ Yes ☐ No Hours Per Week _____

Agency _____

The above services are paid for by: ☐ Medicaid ☐ Medicare ☐ Both ☐ Neither

4. Other Program Participation

I receive the following services:

- ☐ DSS Community Based "Essential" Services (includes homemaker, companion, Meals on Wheels, emergency response system, adult day care).

List services _____ Hours per week _____

_____ Hours per week _____

Total monthly cost of these services, if known _____

Name of Social Worker _____

- ☐ Bureau of Rehabilitation (BRS) Services, please describe:

Name of Counselor _____

- ☐ Services from the Department of Mental Retardation or the Department of Mental Health, please identify:

Total cost of these services, if known _____

Name of your case manager _____

5. Assistance Needs

I need physical (hands on) assistance (check all that apply):

To Be Bathed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To Be Dressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
With Bowel and Bladder Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To Complete Transfers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To Be Fed	<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Financial Data

My total monthly income (not including funds from the programs identified in Section 4) is:

<u>Amount</u>	<u>Source</u>
_____	_____
_____	_____
_____	_____

My total assets are:

<u>Amount</u>	<u>Source</u>
_____	_____
_____	_____
_____	_____

If this form was completed by someone other than the potential applicant, identify that person:

Name _____

Relationship to potential applicant _____

Please explain why this form was not completed by the potential applicant: _____

I attest that the information provided is true and accurate to the best of my knowledge.

Signature of Applicant

Date

Signature of Witness if applicant signs with an X

Date

Signature of person completing this form if other than the applicant

Date

Signature of Conservator, if applicable

Date

**Return This Form To: Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033
Attention: Social Work Services**